STATE OF HAWAI'I PERMIT TO ACQUIRE FIREARMS APPLICATION

Permit Application Number: _____

☐Long Gun Permit to Acquire ☐Pistol/Revolver Permit to Acquire ☐Imported Firearm(s) ☐Use Only Permit

Name: _____
LAST FIRST MIDDLE

Alias/Nickname/Maiden name(List ALL): _____

Social Security Number: _____ Height: _____ Weight: _____ Eyes: _____ Hair: _____

Sex: _____ Date of Birth: _____ Place of Birth (City, State): _____

U.S. Citizen: ☑ YES ☐ NO If NO, Country of Citizenship: _____

Alien or I-94 Admission number: _____

Residence Address: _____
STREET CITY STATE ZIP

Hawai i Address: _____ Address Type: ☐ Residence ☐ Business ☐ Sojourn

Email Address: _____ (optional)

Phone (Home/Cell/Other): _____ Phone (Business): _____

Occupation: _____ Employer: _____ Bus. Address: _____

If firearms are imported, city and state imported from: _____ Date firearms or applicant arrived in Hawai'i (whichever is latest): _____

☐Permit for motion picture films or television program production ONLY [HRS §134-2.5(b)]

Applicant name or officer of firm/corporation Business name Type of business engaged

Business Address Phone

Full description of the use of firearms or explosives

Name of person(s) using props

An application for a permit to acquire firearms shall require the fingerprinting and photographing of the applicant by the police department of the county of registration; provided that where fingerprints and photograph are already on file with the department, these may be waived. [HRS §134-2(b)]

CONTINUE TO FIREARM APPLICATION QUESTIONNAIRE

Exhibit "6"

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FIREARM APPLICATION QUESTIONNAIRE

Please answer the questions below by WRITING YOUR INITIALS on the line under "yes" or "no."	YES	NO
1. Are you a fugitive from justice? [HRS §134-7(a) and 18 U.S.C. §922(g)(2)]	___	___
2. Are you under indictment or information, or have waived indictment, or bound over to the circuit court, in this State or elsewhere, for a crime punishable by imprisonment for a term exceeding one year? [HRS § 134-7(b) and 18 U.S.C. §922(n)]	___	___
3. Have you been convicted, in this State or elsewhere, of a crime punishable by imprisonment for a term exceeding one year? [HRS §134-7(b) and 18 U.S.C. §922(g)(1)]	___	___
4. Are you under indictment or information, or have waived indictment, or bound over to the circuit court, in this State or elsewhere, for any crime of violence or for the illegal sale of any drug? [HRS §134-7(b)]	___	___
5. Have you been convicted, in this State or elsewhere, for any crime of violence or for the illegal sale of any drug? [HRS §134-7(b)]	___	___
6. Are you or have you been under treatment or counseling for addiction to, abuse of, or dependence upon any dangerous, harmful, or detrimental drug, intoxicating compound, or intoxicating liquor, or controlled substance? [HRS §134-7(c)(1)]	___	___
If yes, Include name of treating physician: _____		
7. Are you an unlawful user of or addicted to any controlled substance? [18 U.S.C. §922(g)(3)]	___	___
If yes, Include name of treating physician: _____		
8. Are you authorized to utilize marijuana for medical purposes? [18 U.S.C. §922(g)(3)]	___	___
If yes, please provide expiration date of authorization: _____		
and the state which issued authorization: _____		
9. Have you been acquitted of a crime on the grounds of mental disease, disorder or defect? [HRS §134-7(c)(2)]	___	___
If yes, Include name of treating physician: _____		
10. Have you been adjudicated as a mental defective or have been committed to any mental institution? [18 U.S.C. §922(g)(4)]	___	___
If yes, Include name of treating physician: _____		
11. Have you been diagnosed as having a behavioral, emotional, or mental disorder(s)? [HRS §134-7(c)(3)]	___	___
If yes, Include name of treating physician: _____		
12. Are you or have you been under treatment for organic brain syndrome(s)? [HRS §134-7(c)(3)]	___	___
If yes, Include name of treating physician: _____		

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Please answer the questions below by WRITING YOUR INITIALS on the line under "yes" or "no."

		YES	NO
13.	Are you an illegal alien or unlawfully in the United States? [18 U.S.C. §922(g)(5)(A)]	___	___
14.	Have you been admitted to the United States under a nonimmigrant visa? [18 U.S.C. §922(g)(5)(B)]	___	___
15.	Are you less than 25 years old and have been adjudicated by the family court to have committed a felony, two or more crimes of violence, or an illegal sale of any drug? [HRS §134-7(d)]	___	___
16.	Have you been discharged from the Armed Forces under dishonorable conditions? [18 U.S.C. §922(g)(6)]	___	___
17.	Have you renounced your United States citizenship? [18 U.S.C. §922(g)(7)]	___	___
18.	Are you restrained pursuant to an order of any court, including ex parte order, fro contacting, threatening, or physically abusing (to also include harassing and stalking) any person? [HRS §134-7(f) and 18 U.S.C. §922(g)(8)(A-B)]	___	___
19.	Have you been convicted of a misdemeanor crime of domestic violence? [18 U.S.C. §922(g)(9)]	___	___

20. EXPLANATION FOR ANY 'YES' ANSWERS:

HRS §134-17 Penalties. (a) If any person gives false information or offers false evidence of the person's identity in complying with any of the requirements of this part, that person shall be guilty of a misdemeanor; provided, however that if any person intentionally gives false information or offers false evidence concerning their psychiatric or criminal history in complying with any of the requirements of this part, that person shall be guilty of a class C felony.

****** Do NOT sign until instructed to do so. ******

I declare under penalty of law that the forgoing is true and correct.

SIGNATURE OF APPLICANT _____ DATE _____

SIGNATURE OF ISSUING AUTHORITY _____ BADGE/ID NO. _____ COUNTY OF ISSUING AUTHORITY _____

Revised 10/2017

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APPLICATION FOR PERMIT TO ACQUIRE FIREARMS

Sections 134-2 and 134-3, Hawaii Revised Statutes

Applicant _____
LAST FIRST MIDDLE

Alias(es)/nickname(s)/maiden name _____

Residence address/sojourn _____ Phone _____

Occupation _____ Name of business _____ Phone _____

Rank/grade (military) _____ Business address _____

Place of birth _____ Racial extraction _____ U.S. citizen YES ☐ NO ☐

U.S. passport/naturalization No. _____ Social Security No. _____

Date of birth _____ Height _____ Weight _____ Hair _____ Eyes _____ Sex ____

Acquired from: Name _____ Phone _____

Address _____ Deceased YES ☐ NO ☐

Request permit to acquire the following described handgun(s):

Caliber	Make	Model	Type	Barrel length	Serial No.

As a condition to obtaining a permit to acquire firearm(s), I hereby grant to the Chief of Police of this County access to my medical records which may have a bearing on my mental health relative to conditions listed in the Firearm Application Questionnaire.

Date _____ Signature of Applicant _____

Office of the Chief of Police, City and County of Honolulu

PERMIT TO ACQUIRE FIREARMS

Permission is hereby granted to the above named applicant to acquire the firearm(s) listed in the foregoing application.

Chief of Police, C & C Honolulu

Date: _____ Authorized by: _____

Type of ID used: _____ Investigated by: _____

Person accepting document: _____ Issued by: _____

PHOTO

1st x ☐ 2nd x w/i yr. _____ renewal _____
DATE DATE

Photograph/Fingerprint taken on _____

THIS PERMIT IS VOID AFTER

_____

Upon expiration of this permit, please return it to the Firearms Unit of the Honolulu Police Department

RIGHT THUMB PRINT

HPD-131 (R-12/96)

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PERMIT NO. _____
OUT OF STATE YES ☐ NO ☐

MEDICAL INFORMATION WAIVER
Chapter 134, Hawaii Revised Statutes

I, _____, do freely and in compliance with sections 134-2 and 134-7
(PLEASE PRINT NAME)
of the Hawaii Revised Statutes, authorize the Chief of Police in the City and County of Honolulu access to any and all records which have a bearing on my mental health for the strict purpose of determining my qualification to acquire, own, possess, or have under my control, a firearm.

Name of physician/facility: _____

_____
DOCTOR'S ADDRESS DOCTOR'S TELEPHONE NO.

_____ _____
DATE SIGNATURE OF APPLICANT

_____ _____ _____
WITNESS DATE TIME

HPD-89 (R-05/13)

KAISER PERMANENTE® *HAWAII REGION*

Authorization for Release of Protected Health Information

MR # UC Loc

Name

Sex/BD.

Original: 7/1/98 Revised: 5/8/03 Reviewed:

Date Format: MM / DD / YYYY

1. ***I hereby authorize:***
KAISER PERMANENTE DEPARTMENT OF BEHAVIORAL HEALTH SERVICES
1441 KAPIOLANI BOULEVARD, SUITE 1600
HONOLULU, HAWAII 96814

2. ***Release to:***
A. ☐ Patient or Authorized Representative
B. ☐ Kaiser Permanente Medical Center: 3288 Moanalua Road, Honolulu, Hawaii 96819:
Attention Outpatient Medical Records for: _____
➔ Upon receipt, forward to requester *Physician • Department • Location*
C. ■ Physician, receiving person, agency or institution: CITY AND COUNTY OF HONOLULU, HPD
Address: 801 SOUTH BERETANIA STREET
City: HONOLULU State: HI Zip Code: 96813
Attention: FIREARMS SECTION Dept: _____

3. ***Pertaining to the care of:***
Name: Last _____ First _____ MI _____
MR #: _____ and SS# _____
Also known as: _____ Birthdate ____ / ____ / _____

4. ***For the purpose of:*** DETERMINING AUTHORIZATION FOR ME TO ACQUIRE, OWN, OR POSSESS A FIREARM

5. ***Description of Information:***
Disclosure is authorized for any and all information about medical history, mental and physical condition, including HIV infection, AIDs, or ARC, drug and alcohol use, and other personal information unless otherwise specified.

6. ***Fees:***
A reasonable fee will be charged for duplication of records. An estimate of those charges will be provided upon request prior to duplication.

7. ***Duration of validity:***
This authorization is valid for six (6) months from the date of signing unless revoked in writing by the undersigned prior to six (6) months. The undersigned may revoke this by submitting a letter to Health Information Management Department at 3288 Moanalua Road, Honolulu, Hawaii 96819. I understand that the revocation will not apply to any action taken in reliance on this authorization.

8. ***Re-disclosure:***
The information used and/or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by 45 CFR Subtitle A, Subchapter C, Section 164.508.

9. ***Signature:***
I understand that Kaiser Permanente may not condition treatment, payment, enrollment in the health plan, or eligibility for benefits on my execution of this authorization, except when Kaiser Permanente seeks authorization (1) because it is providing research-related treatment; (2) for purposes of determining health plan eligibility, enrollment underwriting, or risk rating, so long as the authorization is not for use or disclosure of HIPAA psychotherapy notes; or (3) because it is providing treatment solely for the purpose of creating protected health information for disclosure to a third party.

Date ____ / ____ / _____ Signature _____ PH # _____ - _____
Patient • Authorized Representative

If signed by other than patient or parent of minor child, please print name and indicate relationship. Submit documents to show authority to request information on the patient.

Print: _____ _____
Authorized representative's name *Relationship to patient*

Please return a copy of this authorization form with your report. Thank You!

4800 3566 7/03 **White** - OMR/Permits Correspondence **Canary** - Requester Copy

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Office use only: ID Check: _____ MRN: _____
Source: _____ Released By: _____ Date _____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize this provider/facility Straub Clinic and Hospital

located at the following address 888 South King Street Honolulu Hawaii 96813

to use or disclose my individually identifiable health information as described below. I understand that this authorization is voluntary and that this facility will not withhold treatment if I refuse to sign this authorization.

Patient Name: X _____ Date of Birth: X _____ SSN: X _____

Other names I may be known by: _____

Address: X _____

Telephone: Work: X _____ Home: X _____ Other: _____

This authorization covers the services provided during the period of ALL DATES TO PRESENT (mm/dd/yy) to (mm/dd/yy)

Requested format: _____ Electronic Mail _____ CD _____ Paper

I would like to ☒ **Review** ☐ **Copy** ☐ **Request a release of the following information: (check as many as apply)**

- ☐ History and Physical Examination (clinic)
- ☐ History and Physical Report (hospital)
- ☐ Laboratory tests results
- ☐ AIDS or HIV infection/HIV Testing
- ☒ Treatment for alcohol and/or drug abuse
- ☒ Mental health or psychiatric services (*excluding psychotherapy notes*)
- ☐ Progress Notes
- ☐ Discharge Summary
- ☐ Pathology reports
- ☐ ER Records
- ☐ Clinic Visit Notes
- ☐ X-ray reports results
- ☐ X-ray Films
- ☐ Consultation Reports
- ☐ Surgery reports
- ☐ Billing Records
- ☐ Photographs, videotapes, digital or other images
- ☒ Other (please specify) COMPLETE RECORDS

Note: Release of Psychotherapy Notes, as defined by HIPAA Regulations, requires a separate authorization

1. My initials specifically authorize the release of any of the following kinds of information that are or may be in my record **(Note: we will not release your records if they contain any of the following unless initialed by you):**

_____ AIDS or HIV infection or venereal disease X_____ Treatment of alcohol or drug abuse X_____ Mental health(including medications)/psychiatric services

2. This information is to be disclosed for the purpose of: ☐Continuing Health Care ☐Insurance ☐Legal Purposes
   ☒ Other (specify): APPLICATION TO ACQUIRE FIREARMS
3. Information to be released or sent to: Fax: _____
   Name: HONOLULU POLICE DEPARTMENT Telephone: 723-3190
   Address: 801 SOUTH BERETANIA STREET City HONOLULU State HI Zip 96813
4. I understand that if the organization authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations.
5. This facility, its employees, officers, and physicians are released from any legal responsibility or liability for releasing the requested information as authorized.
6. My initials indicate I have read and agree to the following:
   a. **Initials:** X____ I understand that this authorization will expire 1 year from the date signed below or upon the following event or condition _____ unless revoked earlier.
   b. **Initials:** X____ I understand that I may revoke this authorization at any time by notifying this facility in writing. I also understand that revoking this authorization will not apply to any information released by this facility before they received the revocation. (See our *Notice of Privacy Practices* for instructions)
   c. **Initials:** X____ I understand that the provider/facility reserves the right to collect reasonable fees for the copies I have requested.

(Form MUST be completed before signing)

Signature: X _____ Print Name: X _____ Date: X _____

If signed by someone other than the patient, please describe your authority to act on behalf of the Patient:

_____

MAIL OR FAX TO: STRAUB CLINIC AND HOSPITAL, MEDICAL REPORTS DEPARTMENT,
888 So. King St., Honolulu, Hawaii 96813 FAX#: 808/522-3207

Straub
CLINIC & HOSPITAL
An affiliate of Hawaii Pacific Health
888 South King Street Honolulu, Hawaii 96813
Tel: 808-522-4285 Fax: 808-522-3207

Form# 91562 ***rev date 5/2004***

**Mail/Fax/E-mail consent form with a clear copy of your ID (ex. Driver's License, State ID, or passport)*

**Please allow up to 30 days minimum for completion of your request*

Email: _____

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Authorization for Use or Disclosure of Protected Health Information (PHI)

Organization Disclosing PHI	Name of Individual/Organization (other than AMHD) Disclosing PHI
Name: State of Hawaii Adult Mental Health Division (AMHD) PO Box 3378 Honolulu, HI 96801-3378	Name: _____

Organization That Will Receive the Individual's PHI

Honolulu Police Department
801 South Beretania Street
Honolulu, HI 96813

Client/Patient Whose PHI is Being Requested

First Name:	Last name:
Address: _____	Birth date:
	Social Security Number:

I Authorize that the Following Protected Health Information be Used/Disclosed: (PLEASE INITIAL)

_____ Mental Health _____ Substance Abuse Treatment and/or Counseling

The Protected Health Information is Being Used or Disclosed for the Following Purposes (*At the request of the Individual* is an acceptable purpose if the request is made by the individual and the individual does not want to state a specific purpose.):

To determine my qualification to own, possess, or control any firearm or ammunition.

Authorization Duration (This authorization will be in force and effect until the event specified below. At that time, this authorization to use or disclose this protected health information expires).

Expiration of Authorization Event That Relates to the Purpose of the Use or Disclosure:

My disqualification from owning, possessing, or controlling any firearm or ammunition.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the above stated county police department. I understand that a revocation is not effective to the extent that the county police department has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. However, I understand that information related to education (FERPA, 34 CFR Part 99), alcohol or drug treatment services (42 CFR Part 2) may not be redisclosed without my authorization.

Signature:	Date:
Print Name:	

PAID

PERMIT NO. _____

FIREARMS INFORMATION FORM

☐ **Rifle/Shotgun Acquisition** ☐ **Out-of-State Firearm Acquisition** ☐ **Return of Firearm from Evidence**

Name _____
LAST FIRST MIDDLE (MAIDEN NAME)

Address _____ Phone _____

Employer _____ SSN _____

Business address _____ Phone _____

Occupation _____ Rank/grade (military) _____

Date of birth _____ Sex _____ Place of birth _____

U.S. passport/naturalization No. _____ U.S. citizen YES ☐ NO ☐

Racial extraction _____ Height ____' ____" Weight _____ Hair _____ Eyes _____

Acquired from: Name _____ Phone _____

Address _____ Deceased YES ☐ NO ☐

Brought in from: _____
CITY AND STATE (OR CITY AND COUNTRY)

	Caliber	Make	Model (Hand/Rifle/Shotgun) indicate action	Type	Barrel length	Serial No.
1.						
2.						
3.						
4.						
5.						
6.						
7.						

_____ SIGNATURE OF APPLICANT

_____ DATE/TIME

_____ TYPE OF IDENTIFICATION

PHOTO

_____ WITNESS

_____ PERFORMED COMPUTER CHECKS

RIGHT THUMB PRINT

HPD-84 (R-05/13)

COR

C000009

PAID

Payment Method: Cash ☐ Credit Card Ref. # _____

HONOLULU POLICE DEPARTMENT FIREARMS SECTION

State and National Criminal History Record Check
Consent & Notification

Department: HONOLULU POLICE DEPARTMENT

Division: RECORDS AND IDENTIFICATION DIVISION

Applicant Type: FIREARM APPLICANT

Name: (Last, First, Middle) _____

Alias(es): _____

SSN: _____ Sex: _____ Race: _____

Height: _____ Weight: _____ Eye: _____ Hair Color: _____

Place of Birth: _____ Date of Birth: _____

Citizenship: _____

☐ I have not been convicted of a crime.
☐ I have been convicted of the following crime(s):

Describe the crime(s) and the particulars, such as dates, offense, and disposition (attach additional sheets as necessary):

I, the undersigned, hereby authorize the Department/Division listed above to submit a set of my fingerprints to the Hawaii Criminal Justice Data Center (HCJDC) and the Federal Bureau of Investigation (FBI) for the purposes of accessing and reviewing state and national criminal history records that may pertain to me. I understand that my fingerprints will be retained by the HCJDC and the FBI for all purposes and uses authorized for fingerprint submissions, which may include participation in the state and national rap back program.

I understand that I have the right to challenge the accuracy and completeness of the results of my fingerprint-based criminal history record check. Should the Department/Division policy not allow a copy of the results to be given to me, I may obtain a copy of my criminal history record by submitting fingerprints and fees directly to the HCJDC and/or FBI. I understand that the procedures for obtaining a change, correction, or updating of my criminal history record are set forth in Title 28, Code of Federal Regulations, Section 16.34.

I acknowledge that I have read, understand, and agree to the FBI Privacy Act Statement.

Signature: _____ Date: _____

OTN: _____

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